WELBORN HEALTH PLANS

# BENEFIT SUMMARY

*January 1, 2007 ~ December 31, 2007*

## * * * STATE OF INDIANA * * *

### GENERAL BENEFIT LIMITS

Benefit Limit Per Lifetime *(Excluding the separate Maximum Benefit for Organ & Tissue Transplants)*……$2,000,000
Deductible Per Calendar Year (waived for non-tobacco Employees and their dependents)……$500 per person, $500 per family
Out-of-Pocket Maximum……$2,000 per person, $4,000 per family

- Copays do not apply toward the Deductible or Out-of-Pocket Maximum.
- Deductible applies to the Out-of-Pocket Maximum.

### PHYSICIAN OFFICE VISITS

Primary Care Physician Office Visits (Professional Services Fee)……100% Coverage after $20 Copay
Visits to Specialist upon referral (Professional Services Fee)……100% Coverage after $20 Copay

### PHYSICIAN OFFICE OTHER SERVICES

Including, but not limited to: Immunizations and injections; allergy tests and treatment; hearing exams; laboratory, X-ray & other diagnostic services; care of immediate medical need; mammogram, PSA and colorectal exams & testing……100% Coverage (after Deductible)

### PHYSICIAN HOSPITAL SERVICES

Physician Services for Surgery, Visits and Examinations……100% Coverage (after Deductible)

### INPATIENT HOSPITAL SERVICES

Semi-Private Room and Board……100% Coverage after $500 Copay per Admission (after Deductible)
Services include: Private room if medically necessary, Operating, recovery rooms and other special units including intensive care
Maternity care, Hospital ancillary services including laboratory, x-ray, EKG and other diagnostic services
Other services including anesthesia, physical therapy and medications, Administration of blood and blood plasma
Non-experimental organ transplants when prior authorized

### OUTPATIENT SERVICES

Outpatient Surgery……100% Coverage after $250 Copay per Admission (after Deductible)
Outpatient services including laboratory, x-ray, EKG and other diagnostic services…… 100% Coverage (after Deductible)
Other outpatient services for MRI, CT, PET and SPECT……100% Coverage after $50 Copay (after Deductible)
Emergency room services for life-threatening medical emergencies……100% Coverage after $75 Copay per visit (after Deductible) [waived if admitted to hospital]
Immediate/Urgent Care Center visit……100% Coverage after $35 Copay per visit (after Deductible)
Alcohol & Drug Addiction……100% Coverage after $20 Copay per visit (after Deductible)
Hearing Tests……100% Coverage after $20 Copay per visit (after Deductible)
Allergy Testing……100% Coverage after $20 Copay per visit (after Deductible)
Only prepackaged allergy medicines requiring a prescription will be covered under prescription drug section. Serums are not covered under the prescription drug section.

### MENTAL HEALTH SERVICES

Inpatient Mental Health Services for Evaluation……100% Coverage after $500 Copay per Admission (after Deductible)
Outpatient Visits for Psychotherapy, Crisis Intervention or Psychiatric Testing……100% Coverage after $20 Copay
Psychiatric Intensive Outpatient Program (Ambulatory Level Two Mental Health Programs)…… 100% Coverage after $20 Copay

### SUBSTANCE ABUSE SERVICES

Inpatient Substance Abuse Services for Diagnosis and Detoxification……100% Coverage after $500 Copay per Admission (after Deductible)
Outpatient Visits for Evaluation or Crisis Intervention……100% Coverage after $20 Copay (after Deductible)

### OTHER SERVICES

Dialysis……100% Coverage after $20 Copay (after Deductible)
Durable Medical Equipment……80% Coverage (after Deductible)
Emergency Ambulance……100% Coverage after $50 Copay per Transport (after Deductible)
Family Planning including Infertility, Counseling, Testing to Diagnosis, Surgical Treatment & Sterilizations……80% Coverage (after Deductible)
Home Health Care in Lieu of Hospitalization……100% Coverage after $20 Copay per day (after Deductible)
Hospice Care……100% Coverage (after Deductible)
Morbid Obesity Surgery……80% Coverage plus applicable inpatient or outpatient Copay (after Deductible)
Prosthetic Devices and Corrective Appliances……80% Coverage (after Deductible)
Physical, Occupational and Speech Therapy……100% Coverage after $20 Copay per Visit (after Deductible)
Temporomandibular Joint Dysfunction or Disease (TMJ) when medically necessary and prior authorized……Applicable office visit, inpatient or outpatient Copay (after Deductible)

### PRESCRIPTION DRUGS

*Prescription drugs for up to 30-day supply. OTC Select, Generic and Select Prescription Drugs are available through the participating mail order pharmacy for two thirty (30) day supply copayments for a 90-day supply. Non-Select is available for three thirty (30) day supply copaymnets for a 90-day supply. To be covered, certain prescription drugs may require Prior Authorization.*

OTC Select Drugs……$5 Copay
Generic Prescription Drugs……$10 Copay
Formulary Brand Name Drugs and Formulary Diabetic Supplies……$20 Copay
Brand Name or Generic Non-Formulary Drugs……60% Coverage ($40 minimum, $100 maximum)
Biopharmaceutical Drugs/Injectable Drugs……80% Coverage
Diaphragms, Cervical Caps……80% Coverage